NOTIFICATION OF FACILITY ADMISSION/DISCHARGE

Facilities are required to complete this form within 5 days of the resident's admit or discharge. Send completed form to the KanCare Clearinghouse (FAX 1-844-264-6285). This form is not used for persons in an Assisted Living Facility.

A. Resident Information					
First Name:	Last Name:				Gender:
SSN:	Date of Birth:			Client ID #:	
Responsible Person Name:	sponsible Person Name:			Relationship:	
Responsible Person Address:				Ph	one:
B. Facility Information (Assisted	Living – Do Not Co	mplete)			
Facility Name:				PI	none:
Facility Address:			Fax:		
Name of Agency/Person Placing F	Resident:				
Facility NPI:					
Administrator/Designee:					
C. CARE/PASRR/Pre-Admissior					
1. Is a CARE/PASRR/Pre-Admiss	ion Screening Requ	ired? N	0	Yes	
If No, provide reason:					
2. Is a CARE/PASRR/Pre-Admiss	ion Screening subje	ct to Special Ac	dmission?	No	Yes (If yes, complete
the following section): Emergency Admis	sion	Date	to KDADS	S:	
Less than 30 Day	(short-term stay)	Date	to KDADS	S:	
Out of State Admission Da		Date	to KDADS	S:	
Terminal Illness		Date	to KDADS	S:	
3. Was the CARE/PASRR/Pre-Ad	mission Screening (Completed?	No	Yes	Not Applicable
CARE Date:		2, Date:			
If the CARE/PASRR/Pre-A	dmission Screening	g is required, bu	t was not o	completed, list	reason below:
4. Is this a PRTF admission?	No	Yes (if yes, o	complete th	ne following)	
Is there an MCO assigned	? No	Yes If yes,	list the MC	0:	
If an MCO is assigned, has	a prior authorization	on been comple	ted?	No	Yes
If yes, list the date prior au	thorization was com	npleted:		_	

Resident's First Name: D. Facility Admission		Last Name:					
1. Date admitted to you	ur facility:	-					
Anticipated Length of Less that		Anticipated length:	Permanent				
3. Current Level of Care in Your Facility: (items in parentheses are for internal agency use only)							
Skilled Nursing	Facility (IC/NF/SN)	Nursing Facility - Mental Health (IC/NF/MH)					
ICF/IID (IC/NF/DD)		State Hospital - IID (IC/SH/SD)					
Swing Bed (IC/N	NF/SB)	PRTF (IC/BF/MH)					
State Hospital -	- Mental Health (IC/SH/SM)	Head Injury/Rehab. (IC/NF/HI)					
State Institutional Alternative - SIA (IC/SH/SM)							
Resident's Previous Living Arrangement							
4. Was the resident ad	dmitted directly from another facil	lity? No	Yes				
If yes, Name of Facility: Date admitted to this Facility:							
Type of Facility:	Hospital	Nursing Facility					
	Swing Bed	ICF/IID					
	State Hospital	State Institutional Alternat	tive - SIA				
If the resident was not admitted directly from a Facility, list previous living arrangement:							
Own Home Assisted Living Other:							
E. Temporary Absence							
Complete this section only if the resident is absent from the facility more than 30 days and intends to return.							
Name & Address of Facility:							
Type of Facility: Acu	ute Hospital Swing Bed	Other:					
Date Left:	Date Returned:	Or, Anticipate	d Return Date:				
F. Discharged or Deceased							
Complete this section if resident does not intend to return to the facility.							
Date Discharged:	Date Discharged: Date Deceased:						
Discharged to:	Private Home	Facility S	Swing Bed				
	Hospital	Other:					
If discharged to a facility or hospital, name of facility:							
Level of Care at new facility:							

MS-2126 Instructions

- 1. This form can only be submitted by a facility.
- The facility initiates the MS-2126 under the conditions specified in Medical KEESM 8184.1 within 5 days of the 2. event/request. Specific conditions prompting an MS-2126 include:
 - A Medicaid recipient is admitted or discharged from the facility
 - A resident has filed an application for medical assistance
 - · A resident has been absent from the facility for 30 days or longer
 - A resident changes level of care
- 3. Sections A and B are always completed.
- 4. Sections C through F are completed as necessary.
 - Section C: CARE/PASRR/Pre-Admission Screening This section is required for new admissions and new Medicaid requests. Responses to questions 1, 2 and 3 are required for all facilities except PRTF. For PRTF, a response to question 4 is required.

Important: It is the responsibility of the admitting facility to ensure these requirements are met. A CARE Assessment is not required for State Hospitals, SIA, ICF/IID, Swing Bed, or PRTF placements.

- Section D: Facility Admission Required for new admissions, new Medicaid requests and any Level of Care change in the facility.
- · Section E: Temporary Absence A form is only necessary if the resident will be temporarily absent more than 30 days from your facility. If the absence is for 30 days or less, a form is not required. Note regarding a resident temporarily residing in a Swing Bed - the original facility will not be paid for the absence. See the KMAP Provider Manual for information.
- Section F: Discharged or Deceased Complete this section if the resident has discharged and will not return to your facility or if the resident passed away.
- 5. If the resident is in State (DCF or KDOC) or Tribal custody, note this in Section A under Responsible Person or Agency. Contact the designated individual in the DCF Regional Service Center if additional information is needed.
- 6. For PRTF, follow processing guidelines outlined in the appropriate KMAP provider manual regarding prior authorization.
- 7. The facility retains the original MS-2126 and submits a copy to the KanCare Clearinghouse. The form may be faxed (1-844-264-6285) or mailed:

The KanCare Clearinghouse P.O. Box 3599 Topeka, KS 66601-9738

8. The KanCare Clearinghouse will notify the facility when the case is approved or denied.

NOTE: Incomplete forms may not be processed timely and may be returned to the facility.

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